

GLOSSARY

AMERICAN COLLEGE OF EPIDEMIOLOGY: A voluntary society of epidemiologists established to set standards for professional epidemiologists, including a professional code of ethics. [The American College of Epidemiology's web site is: www.ace.org].

AMERICAN NATIONAL STANDARDS INSTITUTE: The American National Standards Institute is a private, non-profit organization that administers and coordinates the U.S. voluntary standardization and conformity assessment system. The Institute's mission is to enhance both the global competitiveness of U.S. business and the U.S. quality of life by promoting and facilitating voluntary consensus standards and conformity assessment systems, and safeguarding their integrity.

ACTIVITIES: Events or actions that take place.

AEA: The American Evaluation Association is a voluntary society of professional evaluators.

BIAS: A deviation of results or inferences from the truth; any trend in the collection, analysis, interpretation, publication, or review of data that can lead to conclusions that are systematically different from the truth.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS): An ongoing, CDC-funded, state-administered, annually conducted survey that produces representative state level profiles of adult health-related behaviors (i.e. smoking, nutrition, exercise, self reported history of ever having been diagnosed as having diabetes, heart disease, etc). The BRFSS data is available from the CDC web site at www.cdc.gov/brfss.

BRP: The national Blue Ribbon Panel of evaluation and community-organization experts developed to serve as advisors to the *CENTERED* Project.

CBOs: Community Based Organizations.

CBPH: Community Based Public Hearth – a strategy for improving the level of health of a community that is driven by the community at all phases (planning, implementation, and evaluation).

CENTERED: A CDC-funded special interest project (1999 SIP25PR) committed to building the evaluation capacity of CBPH programs that are targeting elimination of racial and ethnic disparities in health. *CENTERED* is an acronym that stands for: Community-based Evaluation Networks Targeting Elimination of Racial and Ethnic Disparities. The *CENTERED Project* web site is <http://www.scdhec.net/hs/epi/centered>.

CDC: The Centers for Disease Control and Prevention – that part of the federal Department of Health and Human Services that supports disease prevention and control through public health applications.

COMMUNITIES OF COLOR: African–Americans, Asian-Americans, Hispanic/Latino Americans, Pacific islanders, Native Americans, and Alaskan-Natives.

CONTROL SUBJECTS: Persons similar in nature to your target population, but not enrolled in your program – controls are used to determine the rates of outcome occurrence among persons similar to your program clients, but who have not had the services provided by your program.

DATA TYPES:

Nominal: Unscaled descriptive categories, such as: male, female; urban, rural; African American, Hispanic, American Indian, Asian/Pacific Islander, White).

Ordinal: Relatively scaled categories, such as: <5, 5-9, 10-14, 15+; categories can be organized into rank order, but differences between categories are not measured.

Interval: Measured using a standardized scale so differences are also measurable, such as: height, weight, temperature, blood pressure, etc.

DHHS: The federal Department of Health and Human Services. The federal lead agency in matters related to health. The agency includes the National Institutes of Health, the Food and Drug Administration, and the Centers for Disease Control and Prevention.

ENABLING ENVIRONMENT: Conditions under which the probability that your program will succeed is enhanced.

EVALUATION: The systematic collection, analysis and reporting of information about a program for the purpose of assisting in operational decision making.

EVALUATION TYPES:

Formative – evaluations conducted early in a program to assess processes and program implementation.

Summative – evaluations conducted at the end of a program to inform decisions about a program’s worthiness for continuation or expansion.

EVALUATOR TYPES:

Outside (a.k.a. external or independent): Contracted from an outside agency or organization to conduct the evaluation.

Internal: A staff member charged with the responsibility for evaluations.

FACING THE CHALLENGE OF RACISM AND RACE RELATIONS:

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HEALTHY PEOPLE 2010 (HP2010): The DHHS initiative to improve access to health care and eliminate health disparities -- <http://www.health.gov/healthypeople>.

IMPACTS: Community level changes attributed to program effects may be positive or negative.

INCIDENCE: The rate of occurrence of new cases of the issue of interest during a stated period of time (generally one year) among a defined population. Incidence is calculated by dividing the total number of new cases within the community by the total number of persons at risk within that community. Incidence rates are generally expressed as numbers of cases per 100,000 population.

INDICATOR: Indicators are pieces of information (for example: your body temperature, and “how you feel”) that reflect some larger system (in this case: your general health). Their function is to communicate something about the system without having to spend significant amounts of time and resources seeking comprehensive, detailed information about that system.

INFORMATION TYPES:

Qualitative: Information in the form of text or descriptions, such as interview responses, which are characterized by measurements on a nominal scale or ordinal scale (see Data Types).

Quantitative: Information in the form of numerical quantities such as measurements or counts, which are characterized by measurements on an ordinal or interval scale (see Data Types).

INFORMED CONSENT: A process by which persons in the process of being recruited to participate in studies/evaluations are advised of the study/evaluation and given opportunities to question the proposed nature and extent of that participation and the relevant consequences for themselves and for others; their options are described to them and they are asked to consider granting their consent to participate and to allow the requestor(s) to utilize information provided by them for the specific purposes stated.

INPUTS: The resources invested in the program (money, time, effort, commitment).

INSTITUTIONAL RACISM: The differential access to the goods, services and opportunities of society by race that has been codified in societal structures, processes and values (Jones C, 2000).

INTERNALIZED RACISM: The acceptance by members of the stigmatized “races” of negative messages about their own abilities and intrinsic worth (Jones C, 2000).

INTERVAL DATA: See **DATA TYPES**.

IOM: The Institute Of Medicine, that component of the National Academy of Sciences that deals with health issues.

LOGIC MODEL: An illustration of the steps that you will follow to achieve your target goal; it illustrates the anticipated chain of events that will link your community’s planning and program implementation efforts (**inputs**) to its activities and services (**outputs**) that are intended to produce desired objectives (client **outcomes**) and goals (community level **impacts**).

MEAN: The mean is the mathematical “average” of a set of observations/measurements. The mean is calculated by adding up all observations/measurements and then dividing by the number of observations/measurements. (See Chapter 6).

MEASURES OF CENTRAL TENDANCY: Mean, median, and range of observations/measurements. (See Chapter 6).

MEDIAN: The “middle-most” in a set of observations/measurements; for an odd number of observations/measurements, when the data are arranged in rank order the median is literally the number in the middle (i.e. in a set of nine observations arranged in rank order, the median observation would be the fifth observation in that series); for an even number of observations/measurements, when the data are arranged in rank order the median value is determined by adding up the two middle-most observations and then dividing the sum by two (i.e. in a set of ten observations arranged in rank order, the median observation would be calculated by adding up the values of the fifth and sixth observations and then dividing that sum by two). (See Chapter 6).

“MINORITY”: Often used to refer to non-White persons or communities. This term is not used in this document except when it appears in the name of an agency that has incorporated it into its name or web site. Its continued application to racial/ethnic communities of color has been found to be demeaning and to perpetuate a negative stereotype.

MMWR: Morbidity and Mortality Weekly Report – a weekly publication of the US Public Health Services Centers for Disease Control and Prevention (Atlanta, GA).

NIEHS: National Institute of Environmental Health Sciences (that branch of the National Institutes of Health dealing with environment and its influence on health).

NOMINAL DATA: See **DATA TYPES**.

ORDINAL DATA: See **DATA TYPES**.

OUTCOMES:

- **LONG-TERM (Community Level):** Those benefits or changes in community level indicators (i.e. levels of knowledge, attitudes, behaviors, physical conditions, or health – including the prevalence/incidence of risk behaviors [such as rates of regular exercise, smoking, good nutrition patterns] and disease, use of healthcare services [such as hospitalization or use of emergency department services], and mortality) that occur over longer periods of time – for program activities to affect community level indicators often takes years.
- **MEDIUM-TERM (Client Level):** Those benefits or changes in individual client indicators (i.e. behavior, physical condition, or health) that occur over time as a result of participation in your program’s activities.
- **SHORT-TERM (Client Level):** Those immediate benefits or changes in individual client indicators (i.e. knowledge, attitude, and skills) that occur as a result of participation in your program’s activities.

OUTPUTS: The products, services, or activities produced.

PATHWAYS: An abbreviation for an early *CENTERED Project* publication, *Pathways to Community Based Evaluation* (February, 2000; available from the *CENTERED* web site at www.scdhec.net/hs/epi/centered).

PEOPLE OF COLOR: Refers to non-White people, including African-Americans/Blacks, Asians, Hispanic/Latinos, Pacific Islanders and Native Americans.

PERSONALLY MEDIATED RACISM: The differential assumptions about the abilities, motives, and intents of others by “race”; differential actions towards others by “race”; resulting in prejudice and discrimination (Jones C, 2000).

PRC: Prevention Research Center: One of the centers across the United States funded by CDC’s National Center for Chronic Disease Prevention’s Prevention Research Center’s Program to be a leader in prevention research. Funding for the *CENTERED Project* came through the University of South Carolina Prevention Research Center located within the USC School of Public Health.

PREVALENCE: The rate of existing cases of the issue of interest at a given period of time (“point” prevalence) or during a stated period of time (“period” prevalence; generally one year) among a defined population. Prevalence is calculated by dividing the total number of existing cases (old and new) within the community by the total number of persons within that community. Prevalence rates are generally expressed as numbers of cases per 100,000 population.

PRIMARY DATA: Data that you collect yourself.

PROJECT ADVISORS: Persons who provided input into the *CENTERED Project* on an as needed basis as deemed necessary by either the Project Investigators, CDC, or the Blue Ribbon Panel.

PROJECT INVESTIGATORS: Persons included by name in the grant as part of the core investigative team. Over the course of the *CENTERED Project* there have been four Co-Principal Investigators (one from SC-DHEC and three from the University of South Carolina Norman J. Arnold School of Public Health’s Prevention Research Center).

QA: Quality Assurance – refers to an ongoing data/process monitoring effort to provide assurances of adherence to program protocols and operating procedures, acceptable data quality, and to provide early warnings to assist program management in early identification and resolution of potential problems.

QUALITATIVE DATA: Data collected from interviews, surveys, stories that helps to describe contextual issues (see Chapters 5 & 6).

QUANTITATIVE DATA: Data collected through measurements or counts (see Chapters 5 & 6).

RACISM – see “institutional racism”, “personally-mediated racism”, and “internalized racism”.

RACIAL EQUITY INDICATORS: Relative rates developed by dividing the rates of event/disease occurrence among one racial/ethnic group by those rates for another racial/ethnic group. Racial equity indicators enable a single number description of the relative rate (also known as the “health disparity gap”) to enable monitoring of the size of the disparity gap over time. The national *Healthy People 2010* goal is to eliminate racial/ethnic disparity gaps by the year 2010 – ideally, with the elimination of racial and ethnic disparities in health the racial equity indicators would indicate relative rates at or near 1.0 – indicative of having achieved racial equity for the subject event or disease.

REACH: The Racial and Ethnic Approaches to Community Health Program, a CDC-funded set of CBPH projects that are targeting elimination of health disparities.

RFP: Request For Proposals – one mechanism for use in obtaining bids from potential independent evaluators interested in supporting your evaluation efforts.

SC-DHEC: The South Carolina Department of Health and Environmental Control, the agency responsible for planning and implementing the *CENTERED Project*.

SECONDARY DATA: Data collected by others to which you have access.

SIP: Special Interest Project, a category of research grants funded by CDC’s Center for Chronic Disease Prevention and Health Promotion through the CDC-funded Prevention

Research Centers located at major universities around the nation, including the University of South Carolina, School of Public Health.

STAKEHOLDER: A person, organization, or agency/institution either involved in or affected by your program.

STUDY SUBJECTS: Persons who are enrolled in your program and receiving program services.

SURROGATE OUTCOME INDICATORS: Alternative outcome indicators that are used in evaluations in place of indicators that may be either too rare, too expensive, or too difficult to measure in a timely manner (i.e. while HIV incidence may be the indicator chosen, one might decide instead to use the incidence of other common sexually transmitted agents, such as Chlamydia or Gonorrhea as surrogate outcome indicators for determining if a condom promotion campaign was effective at reducing “STD” incidence with the target community. If the desired changes can be demonstrated using the surrogate indicator).

TEMPORAL TRENDS: Patterns of occurrence or measurement as they occur over time for a specific health/behavioral indicator when measured at predetermined time intervals. For example, if a client is trying to lose weight through participation in your program, you will want to weigh the client when they enter the program and then reweigh the client at regular intervals, such as weekly or monthly, to see not only if weight is being lost, but to also document the client’s weight at specific points in time so comparisons can be made between client weight and program activities or such other outcomes as the client’s involvement in a series of nutritional self-help classes, or participation in a routine exercise program. Temporal trends provide the basis for analyzing whether it is reasonable to attribute changes in the target indicator(s) to the efforts of your program.

USC: University of South Carolina, home of South Carolina’s School of Public Health and the Prevention Research Center – together with CDC and SC-DHEC, USC is a *CENTERED* core agency partner.

YOUTH RISK BEHAVIOR SURVEY (YRBS): An ongoing, CDC-funded, state-administered, survey conducted every 2-years and produces representative state level profiles of adolescents (in grades 9-12) regarding health-related behaviors (i.e. smoking, nutrition, exercise, sexual behaviors, etc). The YRBS data is available from the CDC web site at www.cdc.gov/yrbs.